

**GESTRIDGE DENTAL STUDIO
CONFIDENTIAL MEDICAL HISTORY QUESTIONNAIRE**

SURNAME AND TITLE	
FORENAME	
ADDRESS	
POSTCODE	
TELEPHONE NUMBERS	
DATE OF BIRTH	
OCCUPATION	
NAME AND ADDRESS OF DOCTOR	

**Certain medical conditions can affect dental treatment and vice versa.
Please answer the questions and give details where appropriate.**

Do you have or have ever suffered from:

Heart complaints	
Heart surgery	
Stroke	
Diabetes	
Epilepsy	
Asthma or other respiratory disease	
Hepatitis	
Excessive bleeding	
High blood pressure	
Acid reflux	
HIV	
Please list any allergies	
Do you carry a medical warning card	
Are you taking any medication, both prescribed and self-medicated	
Are you pregnant	
Have you had a joint replacement operation	
What is your weekly consumption of alcohol	
If you smoke, what is your average per week	
With filters	
Without filter	

SIGNATURE.....DATE.....